McMaster Children's Hospital

Please Print Clearly →

PEDIATRIC ECHOCARDIOGRAM REFERRAL

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) | Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F

HIN | Family Physician

Date: (yyyy/mm/dd) _____

Referring Physician _____

Physician's Signature _____

Phone: _____ (ext) _____

Fax: _____

OHIP Billing Number _____

Patient's M # _____

☐ Interpreter required
→ Language _____

☐ CAS / FACS Involvement – (case manager & contact information)
_____

Parent or Guardian Name: _____ **Email:** _____

Current Medication List: ☐ Faxed with Referral **Current Allergy List:** ☐ Faxed with Referral

Request Appointment Date of: (yyyy/mm/dd) _____ **OR:**

☐ Today ☐ Tomorrow ☐ 1 Week ☐ 2 Weeks ☐ 1 Month ☐ 3 Months ☐ 6 Months (follow-up)

Priority: ☐ Routine ☐ Urgent **** Please page the pediatric cardiologist on call if requested appointment date is within 1 week ****

Previous Echo: ☐ Yes, at HHS ☐ Yes, outside HHS ☐ No ☐ Unknown

Anatomical Diagnosis:

☐ Normal ☐ Unknown ☐ Anomalous Pulmonary Venous Return ☐ Aortopulmonary Window
☐ Aortic Arch Abnormalities ☐ Atrial Septal Defect ☐ Atrioventricular Septal Defect
☐ Bicuspid/Dysplastic Aortic Valve ☐ Cardiomyopathy ☐ Common Arterial Trunk and Hemi-Truncus
☐ Coronary Anomoly ☐ Cor Triatriatum ☐ Double Outlet Right Ventricle
☐ Ebstein's / Tricuspid Dysplasia ☐ Hypoplastic Left Syndrome ☐ Isomerism
☐ LVOT Obstruction ☐ Mitral Valve Dysplasia / Prolapse ☐ Patent Ductus Arteriosus ☐ Pericarditis
☐ Pulmonary Atresia ☐ Pulmonary Valve Dysplasia ☐ Tetralogy of Fallot
☐ Transposition of Great Arteries ☐ Tricuspid Atresia ☐ Tumour (Cardiac) ☐ Vascular Ring
☐ Ventricular Septal Defect ☐ Other (please specify) _____

Reason for Exam:

☐ Known Congenital Heart Defect ☐ Abnormal Chest X-ray ☐ Arrhythmia ☐ Cardiac Murmur
☐ Chemotherapy Exposure ☐ Chest Pain ☐ Family History of Cardiomyopathy
☐ Family History of Congenital Heart Defect ☐ Family History of Sudden Death (Under 50 Years)
☐ Genetic Syndrome ☐ Hemoglobinopathies ☐ Hypertension ☐ Kawasaki Disease
☐ Marfan's Syndrome ☐ Muscular Dystrophy ☐ Palpitations / Abnormal ECG
☐ Rule out Pericardial Effusion ☐ Rule out Pulmonary Hypertension ☐ Rule out Vegetation / Clot
☐ Shortness of Breath ☐ Syncope During Exam ☐ Other (please specify) _____

Comments: _____

Please fax legibly completed form and accompanying documentation, including results of tests already completed, to **905-521-5056**. **Incomplete referrals <u>WILL NOT BE PROCESSED.</u>**
If you have any questions about your referral, please contact: (905) 521-2100 ext. 73974
Confirmation of Appointment Date and Time will be provided to the referring physician. It is the referring physician's responsibility to notify their patient of the details.